



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

OCT 07 2002

REGION IV  
Room 3T41  
61 Forsyth Street, S.W.  
Atlanta, Georgia 30303-8909

CIN: A-04-02-02015

Mr. Ardavan Dargahi, MPA, CPAM  
Corporate Compliance Coordinator  
Assistant Chief Compliance Officer  
Public Health Trust/Jackson Health System  
1500 N.W. 12<sup>th</sup> Avenue, Suite 1112  
Miami, Florida 33136

Dear Mr. Dargahi:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, *Review of Medicare Bad Debts for Jackson Memorial Hospital for the Fiscal Year Ended September 30, 1999*. A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by the Public Law 104-231, OIG/OAS reports issued to the Department's grantees and contractors are made available to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (See 45 Code of Federal Regulations Part 5). As such within 10 business days after the final report is issued, it will be posted on the World Wide Web at <http://oig.hhs.gov/>

To facilitate identification, please refer to Common Identification Number (CIN) A-04-02-02015 in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely yours,

Charles J. Curtis  
Regional Inspector General  
for Audit Services, Region IV

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Mr. Dale Kendrick  
Associate Regional Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Sam Nunn Atlanta Federal Center  
61 Forsyth Street, S.W., Suite 4T20  
Atlanta, Georgia 30303-8909

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF  
MEDICARE BAD DEBTS FOR JACKSON  
MEMORIAL HOSPITAL FOR THE FISCAL YEAR  
ENDED SEPTEMBER 30, 1999**



**JANET REHNQUIST**  
**Inspector General**

**OCTOBER 2002**  
**A-04-02-02015**



OCT 07 2002

REGION IV  
Room 3T41  
61 Forsyth Street, S.W.  
Atlanta, Georgia 30303-8909

CIN: A-04-02-02015

Mr. Ardavan Dargahi, MPA, CPAM  
Corporate Compliance Coordinator  
Assistant Chief Compliance Officer  
Public Health Trust/Jackson Health System  
1500 N.W. 12<sup>th</sup> Avenue, Suite 1112  
Miami, Florida 33136

Dear Mr. Dargahi:

This report provides you with the results of our review of inpatient Medicare bad debts at Jackson Memorial Hospital – Miami (Jackson). The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria.

Our review focused primarily on inpatient Medicare bad debts claimed by the hospital totaling \$707,830 during the hospital's fiscal year (FY) ended September 30, 1999.

## EXECUTIVE SUMMARY

We found that, of the \$707,830 claimed for reimbursement as inpatient Medicare bad debts on Jackson's FY 1999 cost report, \$157,179 did not comply with the Medicare reimbursement criteria and was therefore unallowable (see APPENDIX C for financial results of audit). In addition, a limited review of the Medicare bad debt logs for FYs 1997 and 1998 revealed that the Medicare bad debts for those years were overstated by \$168,044 and \$11,412 respectively.

Many of the unallowable bad debts in our review of FY 1999 resulted from the hospital's not making collection efforts on patients who were not indigent. We also found instances of clerical errors, duplicate claims, and inadequate documentation to support that patient indigency determinations were made or that collection efforts were made on indigent patients.

The hospital's policies and procedures were not adequate to assure that Medicare bad debts were properly supported before claiming them on the cost report. The vagueness of the policy on indigent patients and the absence of an automated bad debt log contributed to the unallowable claims.

We are recommending that Jackson establish automated procedures and additional policies to improve their bad debt reporting practices. We also recommend that the hospital file an amended cost report for FY 1999 and reduce allowable bad debts claimed by \$157,179.

In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the fiscal intermediary (FI)) for similar errors as reported here and to ensure that Medicare bad debts comply with the reimbursement criteria. If appropriate, the hospital should file an amended report for FY 2000.

We are sending a copy of this report to the Medicare FI and will recommend to them that they reopen the FY 1997 cost report to reduce allowable Medicare bad debts by \$168,044. We will also recommend that in its ongoing audit of the FY 1998 cost report, the FI include an adjustment to reduce allowable Medicare bad debts by \$11,412.

In written comments to our draft report, the hospital agreed with our findings and has already implemented the majority of our recommendations. The hospital's response included a letter from its patient financial services department in which the major changes in the hospital's policies are highlighted. The full text of the hospital's response is included as Appendix D of the report.

## **BACKGROUND**

Medicare has long had a policy that beneficiaries should share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. For example, during calendar year 2002, the Medicare patient is liable for an \$812 deductible for each benefit period in which they are admitted to a hospital. The patient is also liable for a \$203 a day coinsurance for the 61<sup>st</sup> through the 90<sup>th</sup> day of an extended inpatient stay.

Historically, hospitals have been unable to collect a certain percentage of Medicare coinsurance and deductible amounts from program beneficiaries. Under a policy that costs attributable to Medicare beneficiaries are not to be shifted to non-Medicare patients, Medicare reimburses hospitals for these bad debts. This policy was adopted in 1966 when Medicare reimbursed hospitals retrospectively under reasonable cost principles. Beginning in 1983, inpatient hospital care was reimbursed under a prospective payment system. Under Medicare's prospective payment system, bad debts are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts by submitting annual Medicare cost reports.

Under Section 1861(v)(1)(T) of the Social Security Act, the amount of allowable bad debt for cost reporting periods beginning during FY 1998 was reduced 25 percent. For FY 1999, the amount of allowable bad debt was reduced 40 percent and for FY 2000, it was reduced 45 percent. For the FYs subsequent to FY 2000 it will be reduced 30 percent.

Bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from beneficiaries can be reimbursed to hospitals if the bad debts meet Medicare reimbursement criteria. Generally, bad debts must meet the following criteria, as set forth in Title 42 of the Code of Federal Regulations (CFR) 413.80:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

The Medicare Provider Reimbursement Manual (PRM), Section 310.B, requires that the provider's collection effort be documented in the patient's file, and PRM, Part II, Section 1102, requires that listings be maintained of beneficiaries whose uncollected accounts were claimed as bad debts.

Allowable bad debts must relate to specific deductibles and coinsurance amounts. Under the terms of PRM, Part I, Section 314, uncollectible deductible and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. The specificity required for a bad debt claim is reiterated in the PRM part II. This Center for Medicare & Medicaid Services (CMS) manual requires that certain beneficiary-specific information [such as names and Medicare health insurance number] be sent in by providers claiming reimbursement of bad debts.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria. Our audit covered hospital inpatient Medicare bad debts claimed on the cost report for the cost report year October 1, 1998 through September 30, 1999.

To accomplish our objective, we met with staff at the Medicare FI, First Coast Service Options in Miami, Florida and discussed their role and reviewed their audit work papers and permanent files pertaining to Jackson Hospital. We also met with the State Medicaid agency to determine the State's policy regarding Medicaid reimbursement of Medicare deductibles and coinsurance for Medicare patients who also are eligible for Medicaid.

During our review at the hospital, we reviewed written policies and procedures for collection of patient balances. We reviewed all bad debt entries greater than or equal to \$2,000 and selected 100 entries randomly from the remaining population (for details of the sampling methodology, see APPENDIX A). We performed detailed audit testing on the patient account financial records, Medicare remittance documents, Medicaid remittance documents, and collection activity records for the selected entries. We used the RAT-STATS Variable Appraisal Program to

estimate the dollar impact of improper bad debts in the total population (see APPENDIX B for details on the results of our projection). Finally, we obtained a detail of recoveries of previously written off bad debts to determine how much should have been used to reduce current bad debts.

Because of clerical errors noted on the log for our audit period, and the fact that the hospital's log is not automated, we decided to conduct a limited review of the logs for FYs 1997 and 1998. For those years, we looked for duplicate claims, unusual bad debt amounts, and other unusual items recorded on the logs.

Our review was conducted in accordance with government auditing standards. The review was conducted in February 2002. Our fieldwork was performed at the hospital, the FI (FCSO of Florida, Miami Regional Office) and the Florida State Medicaid Agency in Tallahassee (Agency for Health Care Administration). At the hospital, we relied primarily on substantive testing and as such, an understanding of internal controls of the hospital was not required.

## **RESULTS**

We found that, of the \$707,830 claimed for reimbursement as inpatient Medicare bad debts on Jackson's FY 1999 cost report, \$157,179 did not comply with the Medicare reimbursement criteria and was considered unallowable (see APPENDIX C for financial results of audit). In addition, a limited review of the Medicare bad debt logs for FYs 1997 and 1998 noted that the Medicare bad debts for those years were overstated by \$168,044 and \$11,412 respectively.

Most of the bad debts considered unallowable in FY 1999 resulted from the hospital's inadequate collection effort on patients who were not indigent. One of the criteria for reimbursement of bad debts is that the hospital must demonstrate that reasonable collection efforts were made. However, efforts to collect from the patient may be waived if the patient is determined by the hospital to be indigent. We found that the hospital did not make reasonable collection efforts on many patients even though the patients were not indigent according to the threshold established by the hospital's guidelines.

We also found several patients who the hospital determined to be indigent, however, there was no documentation in the file to support this determination. In the absence of such documentation, the hospital is obligated to demonstrate that reasonable collection efforts were made. In several instances, no collection efforts were documented.

In addition, we found numerous clerical and bookkeeping errors. Based on the condition of the FY 1999 records, we conducted a limited review of prior years' records and found similar errors. The total overstatement of bad debts resulting from these errors was \$11,412 in FY 1998 and \$168,044 in FY 1997.

The hospital's policies and procedures were not adequate to assure that Medicare bad debts were properly claimed. The hospital had not:

- a) established and followed a clear written policy addressing indigent patients; nor
- b) established automated systems to ensure controls that would accumulate accurate Medicare bad debt logs.

We are recommending that the hospital establish automated procedures and additional policies to improve their bad debt reporting practices. We also recommend that the hospital file an amended cost report for FY 1999 and reduce allowable bad debts claimed by \$157,179.

In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the FI) for similar errors as reported here and to ensure that Medicare bad debts comply with the reimbursement criteria. If appropriate, the hospital should file an amended report for FY 2000.

We are sending a copy of this report to the FI and will recommend to them that they reopen the FY 1997 cost report to reduce allowable Medicare bad debts by \$168,044. We will also recommend that in its ongoing audit of the FY 1998 cost report, the FI include an adjustment to reduce allowable Medicare bad debts by \$11,412.

The following sections provide more details on the results of our review.

### **FY 1999 COLLECTION EFFORTS NOT REASONABLE**

The hospital did not conduct reasonable collection efforts on many patient accounts where collection efforts were required before claiming account balances as bad debts. In the absence of reasonable collection efforts, we identified \$11,494 (\$6,134 + \$5,360) in our random sample and \$4,145 in our review of high dollar items that were considered unallowable for Medicare reimbursement. Additionally, the hospital did not adequately document the basis for considering some patients to be indigent; patients for which no collection efforts were made. In the absence of supporting documentation, we identified \$3,060, relating to four patients, which we considered unallowable.

#### **Non-Indigent Patient Accounts Written Off With No Collection Effort**

According to the Medicare guidelines in the PRM-1, Section 312, a hospital may write off a bad debt without collection efforts if the patient is determined by the hospital to be indigent. Otherwise, some collection efforts are required. For some of the patient accounts we reviewed, the hospital inappropriately wrote off the accounts without collection efforts, even though the patients were not indigent, according to the hospital's own definition of indigency.

The hospital did not have written policies regarding the determination of indigence or when not to pursue collections on low-income patients. However, hospital personnel informed us of verbal guidelines which the hospital had been following for many years. According to these guidelines, for patients whose income exceeded 150 percent of the poverty level, the patient was



not considered indigent and the hospital was required to pursue collection of the patient's portion of any account balance. Patients whose income was between 100 percent and 150 percent of the poverty level were considered partially indigent. The hospital was expected to attempt to collect one third of these patients' account balances. Patients whose income was below 100 percent of the poverty level, were deemed to be indigent and no collection effort was required.

We identified 24 patients in our random sample whose income was between 100 percent and 150 percent of the poverty level and had no evidence of collection efforts in their records. According to the hospital's guidelines, the hospital should have attempted to collect at least one third of these patients' account balance. Instead, it appears that the business office wrote off the accounts without attempting to collect the balances. The hospital claimed \$18,404 in bad debts for these 24 patients. Recognizing the hospital's guidelines we considered only one third of this total to be unallowable, or \$6,134. In addition, we found two similarly qualified patients in our review of high dollar items with no collection efforts. The total write-off for these patients was \$12,436, of which we considered \$4,145 to be unallowable.

We also identified seven patients in our sample whose income exceeded 150 percent of the poverty level, yet there was no evidence of collection efforts by the hospital. Again, recognizing hospital guidelines, we considered the entire \$5,360 in bad debts applicable to these patients to be unallowable.

### **No Documentation To Support Patients Considered Indigent**

The PRM-1, Section 312 provisions, which allow a hospital to write off indigent accounts with no collection effort require the hospital to make the determination that the patient is indigent. We found four patient accounts included in our sample that were labeled indigent, yet there was no documentation of the process by which the hospital made this determination. Thus, we were not able to determine if the patients complied with the hospital's guidelines on indigency, or if the hospital even made such a determination. The hospital made no collection efforts on these accounts, which totaled \$3,060. In lieu of adequate documentation to support the patients' indigency status, we consider these patients' bad debts to be unallowable.

### **OTHER ERRORS IN FY 1999**

During our review, we identified other errors that resulted in unallowable bad debt claims in FY 1999.

#### **Hospital Did Not Bill Medicaid**

We found one patient account in our review of high dollar items where the patient had Medicaid coverage and yet the hospital did not bill Medicaid for the inpatient deductible. According to 42 CFR, 413.80, in order to be allowable, a debt must be actually uncollectible when claimed as worthless. The State of Florida has a policy that it will pay for the Medicare deductibles for Medicaid patients who also qualify for Medicare; therefore, the hospital cannot claim that the

account was worthless if it did not bill Medicaid. The total amount claimed for this account was \$764, which we considered unallowable.

### **Bookkeeping Errors**

The hospital made bookkeeping errors to six accounts included in our random sample, which resulted in excessive claims for bad debts. In most of these cases, the hospital did not properly post payments, which had been made on the account. Thus, the bad debt write off amounts were claimed in error. In total, \$3,682 was erroneously claimed on these accounts. Similarly, in our review of high dollar items, we identified two accounts where Medicaid payments were not properly accounted for. On these accounts, Medicaid payments totaling \$30,095 were not posted to the patient accounts, and this total was improperly claimed as a bad debt.

### **Duplicates**

Prior to selecting our sample, we reviewed the bad debt log for duplicate entries and noted there were a total of five duplicate entries on the log totaling \$21,022. Four of these entries were below \$2,000 and totaled \$3,068 and the other duplicate entry was for \$17,954. The total of \$21,022 was not a part of our sample results, and requires a separate adjustment.

### **Bad Debt Not Related To Medicare Deductibles And Coinsurance**

During our review of high dollar bad debts, we identified two bad debts totaling \$21,823 that was not related to Medicare deductibles and coinsurance. The CFR, Title 42, Section 413.80 require that for a bad debt on a Medicare patient to be allowable, it must be related to covered services and be derived from Medicare deductibles or coinsurance. These bad debts did not meet the definition for an allowable claim, thus the \$21,823 is considered unallowable.

### **FY 1999 Summary**

In total, our random sample identified 41 errors representing \$18,236 in bad debts which we considered unallowable. Additionally, we identified seven errors in our review of high dollar items representing \$56,827. As a result, we estimate that the hospital's allowable bad debts were overstated by \$136,157. Adding to this total the \$21,022 of duplicates, in total we consider \$157,179 of the FY 1999 bad debts claimed to be unallowable.

### **PRIOR YEAR COST REPORTS CONTAIN ERRORS**

Based on the results of our review, we conducted a limited review of the bad debts claimed on the FY 1998 and 1997 cost reports, mainly looking for clerical errors in the bad debt logs. We noted numerous duplicates and other errors, which resulted in bad debts being overstated by \$11,412 in FY 1998 and \$168,044 in FY 1997. The following provide more details on each of the FYs.

### Fiscal Year 1998

The hospital's Medicare bad debts were overstated by \$11,412 due to errors in the bad debt log. This amount was made up of duplicate claims, posting errors, and cross year duplicates (amounts that had already been claimed in FY 1997). The errors are summarized as follows:

• Duplicate claims	\$1,520
• Posting error	6,900 (Correct entry of \$764 was entered as \$7,664)
• Cross Year Duplicates	<u>2,992</u>
Total	\$11,412

### Fiscal Year 1997

The hospital's Medicare bad debts were overstated by \$168,044 due to errors on the inpatient acute care, outpatient, end stage renal disease (ESRD), and inpatient psychiatric bad debt logs. The errors in the log represented duplicate claims (\$14,910) and posting errors (\$153,134) as summarized below:

#### SUMMARY OF ERRORS – FY 1997

	Amount Claimed	Less: Adjustments		Total Adjustments	Correct Amount
		Duplicates	Posting Errors		
Inpatient Acute Care	\$ 815,021	\$ (4,132)	\$ -	\$ (4,132)	\$ 810,889
Outpatient	466,427	(7,602)	-	(7,602)	458,825
ESRD	129,265	-	(136,390)	(136,390) (1)	(7,125) (3)
Inpatient Psychiatric	477,017	(3,176)	(16,744)	(19,920) (2)	457,097
Totals	<u>\$1,887,730</u>	<u>\$ (14,910)</u>	<u>\$ (153,134)</u>	<u>\$ (168,044)</u>	<u>\$ 1,719,686</u>

- (1) This posting error was the result of entering a date in the dollar field.
- (2) This posting error was the result of entering the wrong account balance.
- (3) This negative amount is the result of the error exceeding the net bad debt amount claimed. Total ESRD bad debt claimed was \$142,837. This amount was reduced by prior year recoveries of \$13,572, resulting in a net bad debt claimed amount of \$129,265. The error exceeds the net total, resulting in a negative bad debt total if prior year recoveries are considered. Although the balance is negative, an overpayment still exists.

## **CONCLUSION AND RECOMMENDATIONS**

The hospital's Medicare bad debts for FY 1999 included unallowable bad debts totaling \$157,179. The unallowable bad debts were attributable to a lack of reasonable collection efforts and various clerical errors. In addition, we found errors on the Medicare bad debt logs for FYs 1998 and 1997, causing the bad debts for those years to be overstated by \$11,412 and \$168,044 respectively.

We are recommending that Jackson establish automated procedures and additional policies to improve their bad debt reporting practices. The hospital needs to establish a clear written policy for determination of indigency. This will make it obvious to the hospital collection personnel which patients they should try to collect from and which ones they may automatically write off. This change will help to ensure that the hospital complies with the reasonable collection effort requirements included in the criteria for allowable Medicare bad debts. We also recommend that the hospital file an amended cost report for FY 1999 and reduce allowable bad debts claimed by \$157,179.

In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the FI) for obvious errors and to ensure that Medicare bad debts comply with the reimbursement criteria. If appropriate, the hospital should file an amended report for FY 2000.

We are sending a copy of this report to the FI and will recommend to them that they reopen the FY 1997 cost report to reduce allowable Medicare bad debts by \$168,044. We will also recommend that in its currently ongoing audit of the FY 1998 cost report, the FI include an adjustment to reduce allowable Medicare bad debts by \$11,412.

### **Auditee's Comments**

The hospital incorporated its response into the body of our draft report and generally agreed with all of our recommendations. In addition, the hospital included a letter from its patient financial services department explaining the changes to its bad debt collections policies. The following paragraphs provide more specifics on the hospital's response.

The hospital agreed with our recommendation to establish a clear written policy addressing indigent patients. In the letter from the patient financial services department detailing revisions to the Medicare bad debt policy, they indicate that all Medicare patients classified as indigent at the time of admission will have information input into the hospital's computer system. After verification of indigence, the documentation for indigence will be scanned into the imaging system and the account will be referred to Cost and Reimbursement for Medicare bad debt write-off. The hospital agreed with our recommendation to establish automated systems to ensure controls that would accumulate accurate Medicare bad debt logs. The hospital indicated that they had in fact automated their Medicare bad debt logs as of July 1, 2000, which was after the end of the fiscal year we audited, but prior to our audit. In addition, the hospital has modified its

Medicare bad debt logs to include certain data fields that OIG auditors, while at the audit site, had verbally recommended be included.

The hospital indicated that they would request a reopening of the FY 1999 cost report; however, they pointed out that the cost report is not scheduled for audit until January, 2003. The hospital agreed with our recommendation that they review the FY 2000 cost report for similar errors as noted in the report and, if appropriate, file an amended report for FY 2000.

The hospital has reviewed and corrected the errors found by our audit in the FY 1998 bad debt logs and has submitted revised logs to the FI for consideration in its field audit.

### **OIG's Response**

We are pleased that the hospital agrees with our recommendations and has already made changes based on our recommendations. However, the revision to the policy for indigent Medicare accounts does not actually address the need for written policies on how indigence is supposed to be determined. It merely states how indigent accounts will be handled after indigence has been determined and verified. The problems related to indigence noted in this report derived from the fact that the hospital did not have written policies on how to determine indigence and did not follow the verbal guidelines. The revised written policy does not rectify that situation.

In addition, instead of requesting a reopening for the FY 1999 cost report, the hospital should file an amended cost report with the FI since the cost report has not yet been audited.

Sincerely yours,



Charles J,  
Regional Inspector General  
for Audit Services, Region IV

Enclosure

## **SAMPLING METHODOLOGY**

### **OBJECTIVE**

The objective of the audit was to determine if Medicare bad debts claimed by Jackson on its FY ended September 30, 1999 cost report met Medicare requirements.

### **POPULATION**

Jackson's 1999 inpatient Medicare reimbursable bad debts log initially included \$707,830 in bad debt entries consisting of 609 entries. Included in these entries, we noted five duplicates, totaling \$21,022, which needed to be removed. In addition, we noted 15 zero dollar entries, which we removed from the population. Thus, the total population we sampled was \$686,808 (\$707,830 - \$21,022) consisting of 589 entries (609 - 20). Each line item on Jackson's bad debt list (with the zero dollars and duplicates removed) represents a bad debt. There were 31 items that were \$2,000 or greater and 558 under \$2,000.

The population is shown below:

<u>Strata</u>	<u>Number of Bad Debts</u>	<u>Dollar Amount of Bad Debts</u>
Under \$2,000	558	\$ 433,897
\$2,000 and Over	<u>31</u>	<u>\$ 252,911</u>
Total	589	\$ 686,808

### **SAMPLE UNIT**

The sample unit was a bad debt resulting from unpaid coinsurance and deductible amounts.

### **SAMPLE DESIGN**

The sample design is stratified. All items \$2,000 and greater will be included in a separate stratum for 100 percent review. We will then select an unrestricted random sample of items with values less than \$2,000.

### **SAMPLE SIZE**

We randomly selected 100 bad debts that were less than \$2,000, and we reviewed all 31 bad debts that were \$2,000 or greater.

**ESTIMATION METHODOLOGY**

Using the Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services RAT-STATS Variable Appraisal Program for stratified samples, we projected the amount of bad debts that were unsupported, not properly written off, not the proper Medicare deductible and co-insurance amount, claimed on a previous cost report, and paid by the patient or other third party.

## APPENDIX B

### VARIABLE PROJECTION

#### SAMPLE RESULTS

The results of our review are as follows:

<u>Strata</u>	<u>Number of Bad Debts</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
Under \$2000	558	100	\$75,732	41	\$ 18,236
Over \$2000	<u>31</u>	<u>31</u>	<u>\$ 252,911</u>	<u>7</u>	<u>\$ 56,827</u>
Totals	589	131	\$328,643	48	\$75,063

#### VARIABLE PROJECTION

Point Estimate                      \$158,584

90 Percent Confidence Interval

Lower Limit	\$136,157
Upper Limit	\$181,011



## APPENDIX C

**JACKSON MEMORIAL HOSPITAL  
FINANCIAL RESULTS OF AUDIT  
REIMBURSABLE MEDICARE BAD DEBTS  
FY ENDED SEPTEMBER 30, 1999**

	<u>Amount</u>	<u>Notes</u>
Inpatient Medicare Reimbursable Bad Debts Claimed on Cost Report	\$615,804	(a)
Unallowable Bad Debts Identified by OIG in Stratified Sample Testing	\$136,157	(b)
Duplicate Claims Identified and Not Included in Sample Testing	<u>21,022</u>	(c)
Total Disallowance Recommended by OIG	<u>157,179</u>	
Net Allowable FY 1999 Inpatient Medicare Bad Debts	<u><u>\$458,625</u></u>	

**NOTES:**

- (a) This amount represents the total on the inpatient Medicare bad debt log of \$707,830, less the recoveries of \$92,026.
- (b) This represents our projection of the stratified sample results (see APPENDIX B for details).
- (c) These are duplicate entries which were removed from the population before choosing our stratified sample.

APPENDIX D



1611 N.W. 12th Avenue  
Miami, Florida 33136-1094

August 02, 2002

Mr. Charles J. Curtis  
Regional Inspector General  
for Audit Services, Region IV  
Office of Inspector General  
Office of Audit Services  
Region IV  
Room 3T41  
61 Forsyth Street, S.W.  
Atlanta, GA 30303-8909

Via FedEx

Dear Mr. Curtis:

Enclosed is a copy of the draft CIN: A-04-02-02015 from your office and our response that has been written by Cost and Reimbursement and by Patient Financial Services.

Cost and Reimbursement has replied as "*providers response*" within the draft. Patient Financial Services has responded in the attached letter.

If you have any questions please do not hesitate to contact me.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Ardavan Dargahi", is written over a horizontal line.

Ardavan Dargahi, MPA, CPAM  
Assistant Chief Compliance Officer  
Public Health Trust/Jackson Health System

Enclosure- as noted

Cc: Ron Ruppel

Eugene Shy, ESQ

File

**DRAFT**

CIN: A-04-02-02015

Mr. Ardavan Dargahi, MPA, CPAM  
Corporate Compliance Coordinator  
Assistant Chief Compliance Officer  
Public Health Trust/Jackson Health System  
1500 NW 12<sup>th</sup> Avenue Suite 1112  
Miami, Florida 33136

Dear Mr. Dargahi:

This report provides you with the results of our review of inpatient Medicare bad debts at Jackson Memorial Hospital – Miami (Jackson). The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria.

Our review focused primarily on inpatient Medicare bad debts claimed by the hospital totaling \$707,830 during the hospital's Fiscal Year (FY) ended September 30, 1999.

## **EXECUTIVE SUMMARY**

We found that, of the \$707,830 claimed for reimbursement as inpatient Medicare bad debts on Jackson's FY 1999 cost report, \$157,179 did not comply with the Medicare reimbursement criteria and was therefore unallowable (see APPENDIX C for financial results of audit). In addition, a limited review of the Medicare bad debt logs for FYs 1997 and 1998 revealed that the Medicare bad debts for those years were overstated by \$168,044 and \$11,412 respectively.

Many of the unallowable bad debts in our review of FY 1999 resulted from the hospital's not making collection efforts on patients who were not indigent. We also found instances of clerical errors, duplicate claims, and inadequate documentation to support that patient indigency determinations were made or that collection efforts were made on indigent patients.

The hospital's policies and procedures were not adequate to assure that Medicare bad debts were properly supported before claiming them on the cost report. The vagueness of the policy on indigent patients and the absence of an automated bad debt log contributed to the unallowable claims.

We are recommending that Jackson establish automated procedures and additional policies to improve their bad debt reporting practices. We also recommend that the hospital file an amended cost report for FY 1999 and reduce allowable bad debts claimed by \$157,179.

In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the fiscal intermediary) for similar errors as reported here and to ensure that Medicare bad debts comply with the reimbursement criteria. If appropriate, the hospital should file an amended report for FY 2000.

We are sending a copy of this report to the Medicare fiscal intermediary (FI) and will recommend to them that they reopen the FY 1997 cost report to reduce allowable Medicare bad debts by \$168,044. We will also recommend that in its ongoing audit of the FY 1998 cost report, the FI include an adjustment to reduce allowable Medicare bad debts by \$11,412.

## **BACKGROUND**

Medicare has long had a policy that beneficiaries should share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. For example, during Calendar Year 2002, the Medicare patient is liable for an \$812 deductible for each benefit period in which they are admitted to a hospital. The patient is also liable for a \$203 a day coinsurance for the 61<sup>st</sup> through the 90<sup>th</sup> day of an extended inpatient stay.

Historically, hospitals have been unable to collect a certain percentage of Medicare coinsurance and deductible amounts from program beneficiaries. Under a policy that costs attributable to Medicare beneficiaries are not to be shifted to non-Medicare patients, Medicare reimburses hospitals for these bad debts. This policy was adopted in 1966 when Medicare reimbursed hospitals retrospectively under reasonable cost principles. Beginning in 1983, inpatient hospital care was reimbursed under a prospective payment system (PPS). Under Medicare's PPS, bad debts are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts by submitting annual Medicare cost reports.

Under Section 1861(v)(1)(T) of the Social Security Act, the amount of allowable bad debt for cost reporting periods beginning during FY 1998 was reduced 25 percent. For FY 1999, the amount of allowable bad debt was reduced 40 percent and for FY 2000, it was reduced 45 percent. For the FYs subsequent to FY 2000 it will be reduced 30 percent.

Bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from beneficiaries can be reimbursed to hospitals if the bad debts meet Medicare reimbursement criteria. Generally, bad debts must meet the following criteria, as set forth in Title 42 of the Code of Federal Regulations (CFR) 413.80:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;

- the provider must be able to establish that reasonable collection efforts were made;
- the debt was actually uncollectible when claimed as worthless; and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

The Medicare Provider Reimbursement Manual (PRM), Section 310.B, requires that the provider's collection effort be documented in the patient's file, and PRM, Part II, Section 1102, requires that listings be maintained of beneficiaries whose uncollected accounts were claimed as bad debts.

Allowable bad debts must relate to specific deductibles and coinsurance amounts. Under the terms of PRM, Part I, Section 314, uncollectible deductible and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. The specificity required for a bad debt claim is reiterated in the PRM part II. This Center for Medicare & Medicaid Services (CMS) manual requires that certain beneficiary-specific information [such as names and Medicare health insurance number (HIC)] be sent in by providers claiming reimbursement of bad debts.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria. Our audit covered hospital inpatient Medicare bad debts claimed on the cost report for the cost report year October 1, 1998 through September 30, 1999.

To accomplish our objective, we met with staff at the Medicare FI, First Coast Service Options (FCSO) in Miami, Florida and discussed their role and reviewed their audit work papers and permanent files pertaining to Jackson Hospital. We also met with the State Medicaid agency to determine the State's policy regarding Medicaid reimbursement of Medicare deductibles and coinsurance for Medicare patients who also are eligible for Medicaid.

During our review at the hospital, we reviewed written policies and procedures for collection of patient balances. We reviewed all bad debt entries greater than or equal to \$2,000 and selected 100 entries randomly from the remaining population (for details of the sampling methodology, see APPENDIX A). We performed detailed audit testing on the patient account financial records, Medicare remittance documents, Medicaid remittance documents, and collection activity records for the selected entries. We used the RAT-STATS Variable Appraisal Program to estimate the dollar impact of improper bad debts in the total population (see APPENDIX B for details on the results of our projection). Finally, we obtained a detail of recoveries of previously written off bad debts to determine how much should have been used to reduce current bad debts.

Because of clerical errors noted on the log for our audit period, and the fact that the hospital's log is not automated, we decided to conduct a limited review of the logs for FYs 1997 and 1998. For those years, we looked for duplicate claims, unusual bad debt amounts, and other unusual items recorded on the logs.

Our review was conducted in accordance with government auditing standards. The review was conducted in February 2002. Our fieldwork was performed at the hospital, the FI (FCSO of Florida, Miami Regional Office) and the Florida State Medicaid Agency in Tallahassee (AHCA – Agency for Health Care Administration). At the hospital, we relied primarily on substantive testing and as such, an understanding of internal controls of the hospital was not required.

## **RESULTS**

We found that, of the \$707,830 claimed for reimbursement as inpatient Medicare bad debts on Jackson's FY 1999 cost report, \$157,179 did not comply with the Medicare reimbursement criteria and was considered unallowable (see APPENDIX C for financial results of audit). In addition, a limited review of the Medicare bad debt logs for FYs 1997 and 1998 noted that the Medicare bad debts for those years were overstated by \$168,044 and \$11,412 respectively.

Most of the bad debts considered unallowable in FY 1999 resulted from the hospital's inadequate collection effort on patients who were not indigent. One of the criteria for reimbursement of bad debts is that the hospital must demonstrate that reasonable collection efforts were made. However, efforts to collect from the patient may be waived if the patient is determined by the hospital to be indigent. We found that the hospital did not make reasonable collection efforts on many patients even though the patients were not indigent according to the threshold established by the hospital's guidelines.

We also found several patients who the hospital determined to be indigent, however, there was no documentation in the file to support this determination. In the absence of such documentation, the hospital is obligated to demonstrate that reasonable collection efforts were made. In several instances, no collection efforts were documented.

In addition, we found numerous clerical and bookkeeping errors. Based on the condition of the FY 1999 records, we conducted a limited review of prior years' records and found similar errors. The total overstatement of bad debts resulting from these errors was \$11,412 in FY 1998 and \$168,044 in FY 1997.

The hospital's policies and procedures were not adequate to assure that Medicare bad debts were properly claimed. The hospital had not:

- a) established and followed a clear written policy addressing indigent patients; nor

- b) established automated systems to ensure controls that would accumulate accurate Medicare bad debt logs.

**Provider's Response:**

On July 1, 2000, the Cost and Reimbursement Department automated the Medicare bad debt logs. The automation of the logs eliminates all keypunch and clerical errors. A file containing the accounts written off to Medicare bad debt is downloaded to Cost and Reimbursement where it is then transferred to a file containing the fields required for the bad debts log. Once the information is in the format of the bad debt log, it is manually reviewed to verify the following:

That the patient is Medicare

That the amount written-off is for deductible and coinsurance only

If the patient is classified as indigent, the monthly income (if on file) is compared to the poverty guidelines.

If the patient is not indigent, collection efforts are verified

If the account is a Medicare/Medicaid, only the coinsurance is claimed as a bad debt unless Medicaid denies the deductible.

Accounts not passing the above tests are returned to the Business Office for follow-up.

In response to this audit, On June 1, 2002 the Cost and Reimbursement Department modified the Medicare bad debt logs to include the following fields recommended by the OIG auditors:

1. Indigency Code
2. Medicaid Number
3. Remittance Advice Date
4. Date of First Bill Submitted to Beneficiary
5. Zero Balance Date

We are recommending that the hospital establish automated procedures and additional policies to improve their bad debt reporting practices. We also recommend that the hospital file an amended cost report for FY 1999 and reduce allowable bad debts claimed by \$157,179.

**Provider's Response:**

The Provider agrees and has implemented the recommendation regarding the automation of the Medicare bad debt logs. The hospital will request a reopening of the FY 1999 but it should be noted that the FY 1999 cost report will be audited in January of 2003.

In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the FI) for similar errors as reported here and to ensure that

Medicare bad debts comply with the reimbursement criteria. If appropriate, the hospital should file an amended report for FY 2000.

**Provider's Response:**

The hospital agrees with this recommendation.

We are sending a copy of this report to the FI and will recommend to them that they reopen the FY 1997 cost report to reduce allowable Medicare bad debts by \$168,044. We will also recommend that in its ongoing audit of the FY 1998 cost report, the FI include an adjustment to reduce allowable Medicare bad debts by \$11,412.

**Provider's Response:**

The Cost and Reimbursement Department has reviewed and corrected the errors found by the OIG auditors in the 1998 bad debt logs and submitted revised logs to the fiscal intermediary at field audit.

The following sections provide more details on the results of our review.

**FY 1999 COLLECTION EFFORTS NOT REASONABLE**

The hospital did not conduct reasonable collection efforts on many patient accounts where collection efforts were required before claiming account balances as bad debts. In the absence of reasonable collection efforts, we identified \$11,494 (\$6,134 + \$5,360) in our random sample and \$4,145 in our review of high dollar items that were considered unallowable for Medicare reimbursement. Additionally, the hospital did not adequately document the basis for considering some patients to be indigent; patients for which no collection efforts were made. In the absence of supporting documentation, we identified \$3,060, relating to four patients, which we considered unallowable.

**Non-Indigent Patient Accounts Written Off With No Collection Effort**

According to the Medicare guidelines in the PRM-1, Section 312, a hospital may write off a bad debt without collection efforts if the patient is determined by the hospital to be indigent. Otherwise, some collection efforts are required. For some of the patient accounts we reviewed, the hospital inappropriately wrote off the accounts without collection efforts, even though the patients were not indigent, according to the hospital's own definition of indigence.

The hospital did not have written policies regarding the determination of indigence or when not to pursue collections on low-income patients. However, hospital personnel informed us of verbal guidelines which the hospital had been following for many years. According to these guidelines, for patients whose income exceeded 150 percent of the poverty level, the patient was not considered indigent and the hospital was required to pursue collection of the patient's portion



of any account balance. Patients whose income was between 100 percent and 150 percent of the poverty level were considered partially indigent. The hospital was expected to attempt to collect one third of these patients' account balances. Patients whose income was below 100 percent of the poverty level, were deemed to be indigent and no collection effort was required.

We identified 24 patients in our random sample whose income was between 100 percent and 150 percent of the poverty level and had no evidence of collection efforts in their records. According to the hospital's guidelines, the hospital should have attempted to collect at least one third of these patients' account balance. Instead, it appears that the business office wrote off the accounts without attempting to collect the balances. The hospital claimed \$18,404 in bad debts for these 24 patients. Recognizing the hospital's guidelines we considered only one third of this total to be unallowable, or \$6,134. In addition, we found two similarly qualified patients in our review of high dollar items with no collection efforts. The total write-off for these patients was \$12,436, of which we considered \$4,145 to be unallowable.

We also identified seven patients in our sample whose income exceeded 150 percent of the poverty level, yet there was no evidence of collection efforts by the hospital. Again, recognizing hospital guidelines, we considered the entire \$5,360 in bad debts applicable to these patients to be unallowable.

### **No Documentation to Support Patients Considered Indigent**

The PRM-1, Section 312 provisions, which allow a hospital to write off indigent accounts with no collection effort require the hospital to make the determination that the patient is indigent. We found four patient accounts included in our sample that were labeled indigent, yet there was no documentation of the process by which the hospital made this determination. Thus, we were not able to determine if the patients complied with the hospital's guidelines on indigency, or if the hospital even made such a determination. The hospital made no collection efforts on these accounts, which totaled \$3,060. In lieu of adequate documentation to support the patients' indigency status, we consider these patients' bad debts to be unallowable.

### **Provider's Response (PFS):**

### **OTHER ERRORS IN FY 1999**

During our review, we identified other errors that resulted in unallowable bad debt claims in FY 1999.

### **Hospital Did Not Bill Medicaid**

We found one patient account in our review of high dollar items where the patient had Medicaid coverage and yet the hospital did not bill Medicaid for the inpatient deductible. According to 42 CFR, 413.80, in order to be allowable, a debt must be actually uncollectible when claimed as

worthless. The State of Florida has a policy that it will pay for the Medicare deductibles for Medicaid patients who also qualify for Medicare; therefore, the hospital cannot claim that the account was worthless if it did not bill Medicaid. The total amount claimed for this account was \$764, which we considered unallowable.

**Provider's Response:**

The addition to the log of the Medicaid number will insure that no bad debts for deductibles will be written-off unless Medicaid has denied the deductible.

**Bookkeeping Errors**

The hospital made bookkeeping errors to six accounts included in our random sample, which resulted in excessive claims for bad debts. In most of these cases, the hospital did not properly post payments, which had been made on the account. Thus, the bad debt write off amounts were claimed in error. In total, \$3,682 was erroneously claimed on these accounts. Similarly, in our review of high dollar items, we identified two accounts where Medicaid payments were not properly accounted for. On these accounts, Medicaid payments totaling \$30,095 were not posted to the patient accounts, and this total was improperly claimed as a bad debt.

**Provider's Response (PFS Billing and Collections)**

**Duplicates**

Prior to selecting our sample, we reviewed the bad debt log for duplicate entries and noted there were a total of five duplicate entries on the log totaling \$21,022. Four of these entries were below \$2,000 and totaled \$3,068 and the other duplicate entry was for \$17,954. The total of \$21,022 was not a part of our sample results, and requires a separate adjustment.

**Provider's Response:**

The Cost and Reimbursement Department has a computer program in place that eliminates duplicate entries in the Medicare bad debt logs.

**Bad Debt Not Related to Medicare Deductibles and Coinsurance**

During our review of high dollar bad debts, we identified two bad debts totaling \$21,823 that was not related to Medicare deductibles and coinsurance. The CFR, Title 42, Section 413.80 require that for a bad debt on a Medicare patient to be allowable, it must be related to covered services and be derived from Medicare deductibles or coinsurance. These bad debts did not meet the definition for an allowable claim, thus the \$21,823 is considered unallowable.

**Provider's Response:**

The Cost and Reimbursement Department has implemented a computer program that verifies that the amounts in the Medicare bad debt logs are related only to deductible and coinsurance amounts. This program compares the amounts in the bad debt logs to the coinsurance and deductible amounts in the Medicare remittance advice log

**FY 1999 Summary**

In total, our random sample identified 41 errors representing \$18,236 in bad debts which we considered unallowable. Additionally, we identified seven errors in our review of high dollar items representing \$56,827. As a result, we estimate that the hospital's allowable bad debts were overstated by \$136,157. Adding to this total the \$21,022 of duplicates, in total we consider \$157,179 of the FY 1999 bad debts claimed to be unallowable.

**PRIOR YEAR COST REPORTS CONTAIN ERRORS**

Based on the results of our review, we conducted a limited review of the bad debts claimed on the FY 1998 and 1997 cost reports, mainly looking for clerical errors in the bad debt logs. We noted numerous duplicates and other errors, which resulted in bad debts being overstated by \$11,412 in FY 1998 and \$168,044 in FY 1997. The following provide more details on each of the FYs.

**DRAFT****Fiscal Year 1998**

The hospital's Medicare bad debts were overstated by \$11,412 due to errors in the bad debt log. This amount was made up of duplicate claims, posting errors, and cross year duplicates (amounts that had already been claimed in FY 1997). The errors are summarized as follows:

- Duplicate claims \$1,520
- Posting error 6,900 (Correct entry of \$764 was entered as \$7,664)
- Cross Year Duplicates 2,992
- Total \$11,412

**Fiscal Year 1997**

The hospital's Medicare bad debts were overstated by \$168,044 due to errors on the inpatient acute care, outpatient, end stage renal disease (ESRD), and inpatient psychiatric bad debt logs. The errors in the log represented duplicate claims (\$14,910) and posting errors (\$153,134) as summarized below:

**SUMMARY OF ERRORS – FY 1997**

	Amount Claimed	Less: Adjustments			Correct Amount
		Duplicates	Posting Errors	Total Adjustments	
Inpatient Acute Care	\$ 815,021	\$ (4,132)	\$ -	\$ (4,132)	\$ 810,889
Outpatient	466,427	(7,602)	-	(7,602)	458,825
ESRD	129,265	-	(136,390)	(136,390) (1)	(7,125) (3)
Inpatient Psychiatric	477,017	(3,176)	(16,744)	(19,920) (2)	457,097
Totals	<u>\$1,887,730</u>	<u>\$ (14,910)</u>	<u>\$ (153,134)</u>	<u>\$ (168,044)</u>	<u>\$ 1,719,686</u>

- (1) This posting error was the result of entering a date in the dollar field.
- (2) This posting error was the result of entering the wrong account balance.
- (3) This negative amount is the result of the error exceeding the net bad debt amount claimed. Total ESRD bad debt claimed was \$142,837. This amount was reduced by prior year recoveries of \$13,572, resulting in a net bad debt claimed amount of \$129,265. The error exceeds the net total, resulting in a negative bad debt total if prior year recoveries are considered. Although the balance is negative, an overpayment still exists.

**DRAFT**

**CONCLUSION AND RECOMMENDATIONS**

The hospital's Medicare bad debts for FY 1999 included unallowable bad debts totaling \$157,179. The unallowable bad debts were attributable to a lack of reasonable collection efforts and various clerical errors. In addition, we found errors on the Medicare bad debt logs for FYs 1998 and 1997, causing the bad debts for those years to be overstated by \$11,412 and \$168,044 respectively.

We are recommending that Jackson establish automated procedures and additional policies to improve their bad debt reporting practices. The hospital needs to establish a clear written policy for determination of indigency. This will make it obvious to the hospital collection personnel which patients they should try to collect from and which ones they may automatically write off. This change will help to ensure that the hospital complies with the reasonable collection effort requirements included in the criteria for allowable Medicare bad debts. We also recommend that the hospital file an amended cost report for FY 1999 and reduce allowable bad debts claimed by \$157,179.

In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the FI) for obvious errors and to ensure that Medicare bad debts comply with the reimbursement criteria. If appropriate, the hospital should file an amended report for FY 2000.

We are sending a copy of this report to the FI and will recommend to them that they reopen the FY 1997 cost report to reduce allowable Medicare bad debts by \$168,044. We will also recommend that in its currently ongoing audit of the FY 1998 cost report, the FI include an adjustment to reduce allowable Medicare bad debts by \$11,412.

## SAMPLING METHODOLOGY

### OBJECTIVE

The objective of the audit was to determine if Medicare bad debts claimed by Jackson on its FY ended September 30, 1999 cost report met Medicare requirements.

### POPULATION

Jackson's 1999 inpatient Medicare reimbursable bad debts log initially included \$707,830 in bad debt entries consisting of 609 entries. Included in these entries, we noted five duplicates, totaling \$21,022, which needed to be removed. In addition, we noted 15 zero dollar entries, which we removed from the population. Thus, the total population we sampled was \$686,808 (\$707,830 - \$21,022) consisting of 589 entries (609 - 20). Each line item on Jackson's bad debt list (with the zero dollars and duplicates removed) represents a bad debt. There were 31 items that were \$2,000 or greater and 558 under \$2,000.

The population is shown below:

<u>Strata</u>	<u>Number of Bad Debts</u>	<u>Dollar Amount of Bad Debts</u>
Under \$2,000	558	\$ 433,897
\$2,000 and Over	<u>31</u>	<u>\$ 252,911</u>
Total	589	\$ 686,808

### SAMPLE UNIT

The sample unit was a bad debt resulting from unpaid coinsurance and deductible amounts.

### SAMPLE DESIGN

The sample design is stratified. All items \$2,000 and greater will be included in a separate stratum for 100 percent review. We will then select an unrestricted random sample of items with values less than \$2,000.

### SAMPLE SIZE

We randomly selected 100 bad debts that were less than \$2,000, and we reviewed all 31 bad debts that were \$2,000 or greater.

**DRAFT**

**APPENDIX A**

Page 2 of 2

**ESTIMATION METHODOLOGY**

Using the Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services RAT-STATS Variable Appraisal Program for stratified samples, we projected the amount of bad debts that were unsupported, not properly written off, not the proper Medicare deductible and co-insurance amount, claimed on a previous cost report, and paid by the patient or other third party.

## DRAFT

### APPENDIX B

#### VARIABLE PROJECTION

##### SAMPLE RESULTS

The results of our review are as follows:

<u>Strata</u>	<u>Number of Bad Debts</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
Under \$2000	558	100	\$75,732	41	\$ 18,236
Over \$2000	<u>31</u>	<u>31</u>	<u>\$ 252,911</u>	<u>7</u>	<u>\$ 56,827</u>
Totals	589	131	\$328,643	48	\$75,063

#### VARIABLE PROJECTION

Point Estimate                      \$158,584

90 Percent Confidence Interval

Lower Limit	\$136,157
Upper Limit	\$181,011



# DRAFT

## APPENDIX C

### JACKSON MEMORIAL HOSPITAL FINANCIAL RESULTS OF AUDIT REIMBURSABLE MEDICARE BAD DEBTS FY ENDED SEPTEMBER 30, 1999

	<u>Amount</u>	<u>Notes</u>
Inpatient Medicare Reimbursable Bad Debts Claimed on Cost Report	\$615,804	(a)
Unallowable Bad Debts Identified by OIG in Stratified Sample Testing	\$136,157	(b)
Duplicate Claims Identified and Not Included in Sample Testing	<u>21,022</u>	(c)
Total Disallowance Recommended by OIG	<u>157,179</u>	
Net Allowable FY 1999 Inpatient Medicare Bad Debts	<u><u>\$458,625</u></u>	

#### NOTES:

- (a) This amount represents the total on the inpatient Medicare bad debt log of \$707,830, less the recoveries of \$92,026.
- (b) This represents our projection of the stratified sample results (see APPENDIX B for details).
- (c) These are duplicate entries which were removed from the population before choosing our stratified sample.

2 August 2002

CIN: A-04-02-02015

Mr. Ardavan Dargahi, MPA, CPAM  
Corporate Compliance Coordinator  
Assistant Chief Compliance Officer  
Public Health Trust/Jackson Health System  
1500 NW 12<sup>th</sup> Avenue Suite 1112  
Miami, Florida 33136

Dear Mr. Dargahi:

The PHT/JHS Finance Department Billing Section completed a revision of the Medicare Bad Debt policy. The revisions include:

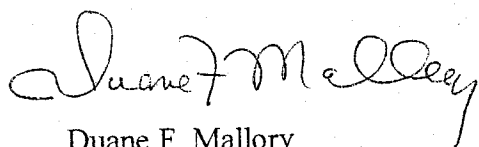
All Medicare patients classified, as indigent by Patient Access at the time of admission or registration will have information in-putted into the Hospital computer system (CARE System). The documentation after verification of indigence status will be scanned into the imaging system, the account will then be referred to Cost and Reimbursement for Medicare bad debt write-off.

A reasonable collection effort policy for non-indigent patients has been established. The External Collection Agencies will receive accounts that are self-pay and patients with incomplete indigence documentation, for the remaining balance of the deductible and/or co-insurance. All uncollected accounts with patient responsibility are sent to the collection agency. The Collection Agency must make a reasonable collection effort (four letters from the first billing cycle or telephone calls to receive payment on the patient portion balance due and/or to complete the attestation form. These attempts must state the patients' responsibility for the balance of the co-insurance and deductible). (See §310 and 42 CFR 413.80.)

If after 120 days (4 billing cycles from the 1<sup>st</sup> billing date) of receipt of the Medicare payment and the patient is notified of their responsibility (co-insurance and/or deductible) and unsuccessful collection from the collection agency, then the account will be returned to the Medicare Department for pre close back review of collection efforts. The Credit Representative will review the account and refer to the Cost and Reimbursement Department for bad debt write-off.

On accounts where collection efforts are questionable the Medicare Department will not accept and will refer back to the agencies for additional collection efforts.

In pursuance to Medicare Provider Reimbursement Manual section (§310.2) if after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

A handwritten signature in cursive script, reading "Duane F. Mallory". The signature is written in dark ink and is positioned above the printed name.

Duane F. Mallory  
Medicare Billing

---

**JACKSON MEMORIAL  
HOSPITAL**

**Section: MEDICARE BILLING  
OPERATIONAL PROCEDURE**

**FINANCE DIVISION  
POLICY AND PROCEDURE MANUAL**

**Subject: MEDICARE BAD DEBT  
POLICY**

---

**POLICY:**

It will be the policy of the Medicare Billing and Collections Department to adhere to Medicare regulations regarding allowable bad debts.

**PROCEDURE:**

- I. The Medicare Billing and Collections Department will ensure that bad debt claims comply with HCFA requirements.
  - A. A Medicare Bad Debt is:
    1. The unpaid account receivable portion attributed to the patient's deductible and coinsurance amounts.
  - B. A Medicare Bad Debt is Not:
    1. The unpaid non-covered charges included in the patient's bill or,
    2. The unpaid physician charges included in the patient's bill.
  - C. The hospital admission and registration is the process of obtaining and verifying the necessary financial and medical information at the time the patient arrives to be admitted or treated.
  - D. Inpatient Patient Admission and Outpatient Registration now known as Patient Access Services will consistently document complete and accurate demographic, financial and insurance information. All patients will be required to complete the Income/Indigence Attestation Form as stated in the Jackson Memorial Hospital, Patient Financial Services Policy and Procedure, Manual Code 410.09.
  - E. Outpatients will be classified on the Hill Burton scale. Financial information must be documented in the Registration Credit Information Screen. A printout of this Registration Summary, the signed Income/Indigence Attestation Form, Medicare Payment Authorization and Exclusion Explanation Form will be forwarded to the Imaging Department to be scanned and made available for audit purposes.

- D. This Registration Summary will indicate the Credit Level assigned to the patient as determined by utilizing the current Poverty Guidelines of the Federal Government (Hill Burton Scale). These guidelines are used to assist in establishing reasonable payment schedules. Other financial criteria shall be considered, including, but not limited to, pertinent medical, social, and economic factors such as ownership of real estate and personal property. The patient is required to furnish documentation pertaining to income, taxes, Social Security, Medicaid, bank accounts, and other personal assets and liabilities. This data will be used only for determining reasonable ability to pay.
- E. This hospital does not waive the deductible or coinsurance for Medicare patients.
- F. The credit levels for Medicare Outpatient documented in the CARE System are as follows:
- (A05) Indigent patients with Medicare card,
  - (XB) Medicare Part A and Medicare Part B Benefits, or Medicare Part B Benefits only,
  - (A04) Patients who have Medicare with Medicaid,
  - (XBW) Patient has Medicare Part A and Medicare Part B, or Medicare Part B Benefits only, and Medicaid,
  - (A06) Patient with Medicare Part A and Medicare Part B only—patient pays what Medicare does not pay. A patient with Blue Cross- Blue Shield supplemental insurance is an automatic Medicare cross over for co-insurance and deductible.
- The patient pays the yearly deductible and coinsurance amount plus any charges not Covered by the Medicare Program,
- Medicare Part A is Hospital Benefits,  
Medicare Part B is Medical Benefits.
- G. the credit levels for Medicare Inpatient documented in the CARE System are as follows:
- (A27) Indigent patients with Medicare Part A and Medicare Part B and Medicare Part A only,  
(YB)
  - (A07) Indigent patients with Medicare Part B only,  
(YB)
  - (A17) Patient who have Medicare and Medicaid,  
(B97) Patient has Medicare Part A and Medicare Part B or Medicare Part A only,  
(XBW)
  - (A97) Patients with Medicare Part A and Medicare Part B or  
(YB) Part A only,  
Patient pays what Medicare does not pay,  
The patient pays the yearly deductible and coinsurance.

H. Indigent Patients Referred To Medicare Bad Debt:

Medicare Outpatient accounts for indigent (A05) patients will be contractually adjusted at the time of the Medicare payment through Postpro (an automated payment and contractual posting system for electronic remittances).

1. **Procedures:**

Medicare Bad Debt contractual adjustments to indigent Medicare accounts,

a. Contractual Adjustments to Outpatient Indigent Medicare Accounts.

- **Medicare B Bad Debt Write-Off (85301-0)**

The account will be assigned a suffix "D5" or "R5" to identify the indigent Medicare patient. These patients are eligible for the Medicare Part B Bad Debt Write-Off (85301-0). The sum of the deductible amount plus the co-insurance amount from the Medicare remittance will be written off through Postpro using Transaction Code 0085301.

The Data Control Department will print one copy of the Remittance Advice for the Cost and Reimbursement Department which is necessary for reporting the Medicare Part B Bad Debt Write-Off to the Medicare Cost Report and the Medicare Auditors.

b. Contractual Adjustments to Inpatient Indigent Medicare Accounts

- Patient accounts which are established to be indigent, by Patient Access Services, will be referred to the Cost and Reimbursement Department after Medicare payment is received for the appropriate Medicare Bad Debt Write-Off, to be reported on the Medicare Cost Report. The following Medicare Bad Debt Write-Off transaction codes will be used:

Acute:	85501-5
Psych:	88901-6
Rehab:	86901-6

c. When Medicare Part A benefits are exhausted, ancillary charges will be billed to Medicare Part B. Once the Medicare payment is received, the coinsurance is written off to Medicare Part B Bad Debt using the following transaction codes:

Acute:	85301-0
Psych:	88901-4
Rehab:	88801-6

- I. The Inpatient Medicare Billing Department will mail an itemized bill to the patient after discharge, upon patients request.
- J. An automated monthly statement of account is mailed by the hospital to all Medicare patients, if the balance due is the patient's responsibility.
- K. **When the Credit Representative determines the documentation on file to support indigence for the Medicare patient is not substantiated, the Credit Representative will refer accounts with a balance for co-insurance and or a deductible to the collection agency for follow-up with patient and insurance company.**
- L. Referral of Medicare Accounts with balances (Self Pay and Supplemental Insurance) to a Collections Agency
  1. The Medicare Billing and Collections Department will analyze the Account Receivables before the account is referred to an outside collections agency.
    - a. Medicare (YB) Accounts
      - Medicare (YB) accounts will be referred to outside collection agencies after payment is received from Medicare, the same as the criteria for referring a non-Medicare self-pay account to a collection agency.  
  
Inpatient Medicare (YB) accounts for balances over \$100  
Outpatient Medicare (YB) accounts for balances over \$25
      - The Billing and Collections Department staff will transfer the account to the collection agency using Finance's policy and procedure.
    - b. The Collections Agency will process these Accounts Using the Following Guidelines:
      - Read and use HBOC account comments to determine and confirm dollar amount of deductible and/or co-insurance owed per account balances.
      - Attempt to collect account balances for deductible and co-insurance from either the patient 's supplemental insurance carrier, as applicable within 120 days.
      - The Collection Agency attempts should be by means of 3 letters within 120 days to the patients and pursue normal collection efforts on claims owed by the supplemental insurance carriers.

- The collection agency will document in their internal collection system all collection agency's activities.
- Any account the collection agency determines to be uncollectable after 120 days, (for the purpose of Medicare Bad Debt write off) will be closed back on a monthly report, with attachments for outpatient accounts and documentation is scanned in the imaging system for inpatient accounts (showing three serious collection attempts have been made). The report should be sorted as inpatient and outpatient, and should be in alpha order. Once this is verified by the Credit Representative, the account is accepted by the Medicare Department for referral ( write off) to the Cost and Reimbursement Department.

2. Policy and Procedure for Collection Agencies

a. Medicare Deductibles and Coinsurance Amounts Due for Plan Codes

A06 - Patient responsible, with or without insurance, outpatient

A97 - Patient responsible, with or without insurance, inpatient – ACUTE  
M17 - Blue Cross/Blue Shield Supplement

A98 - Patient responsible, with or without insurance, inpatient – PSYCH  
297 - Other Commercial Insurance

A99 - Patient responsible, with or without insurance, inpatient – REHAB  
297 - Other Commercial Insurance

- b. After reasonable attempts to collect within 120 days, from the patient are documented by the collections agency and it is determined that this account is uncollectable, the following procedure will be observed.

- M. The account will be returned to Jackson Memorial Hospital's Medicare Department within 120 days with close-back monthly report for reconciling the account to a personal computer listing. The adjustments will be posted on-line for private room and non-covered charges as determined by the Credit Representative based on the information included in the account. The deductible and co-insurance will be sent to Cost and Reimbursement for write-off to Medicare Bad Debt for cost reporting purposes.
- N. All policies and all personnel will be governed by regulations as set forth in the subsequent pages.



## **II. Medicare Reimbursement Policy for Allowable Bad Debt**

### **A. Background**

1. Regulation 42 CFR, Section 413.80, and HCFA Publication 15-1, Section 308 set forth Medicare's criteria for allowable bad debt as follows:
2. The debt must be related to covered services and derived from deductible and co-insurance amounts.
3. The provider must be able to establish that reasonable collection efforts were made (Reference HCFA Pub. 15-1), Section 310.
4. The debt was actually uncollectible when claimed as worthless.
5. Sound business judgement established that there was no likelihood of recovery at any time in the future.

### **M. Current Environment**

1. Office of Inspector General's (OIG) National Audit Intermediaries and Published Findings

#### **a. HCFA's Expectations of Intermediaries:**

HCFA expects intermediaries to adhere to Medicare policy regarding bad debt claims. The Intermediary's audit of bad debt claims will be governed by program policy outlined in Regulation 42 CFR, Section 413.80, and HCFA Pub. 15-1, Chapter 3.

## **III. Blue Cross/Blue Shield of Florida (Medicare Intermediary) Expectations of Providers**

### **A. Adherence to Medicare Policy**

1. To be allowed a bad debt claim, the provider must demonstrate by auditable documentation that:
  - Bad Debts meet requirements of HCFA Pub. 15-1, Section 308, and "Reasonable Collection Efforts", per Section 310, (e.g., "Reasonable Collection Efforts" start with putting forth similar efforts to collect Medicare deductible and coinsurance amounts as the effort put forth for comparable amounts of non-Medicare patient accounts receivable).

## **IV. Reimbursement Issues**

### **A. Documentation of Reasonable Collection Efforts**

1. Must be similar and consistent to effort put forth to collect comparable amounts from non-Medicare patients.

2. Must involve issuance of a bill, on or shortly after discharge or death of the patient, to the party responsible for the patient's financial obligations.
3. Effort must be genuine rather than a token collection effort (e.g., subsequent billings, collection letters, telephone calls, etc).

B. 120 Day Rule

1. This rule means that a debt is considered to be uncollectible if 120 days have elapsed from the date the first bill was furnished to patient and reasonable collection efforts have been exhausted.

C. Indigence Determinations

1. The provider must determine the patient's indigence and include the documentation in the patient's file.

V. Providers's Recordkeeping Requirements

A. Ensure That Bad Debts Claimed Are:

1. only for unpaid deductible and co-insurance,
2. written-off and claimed when reasonable collection efforts have been made. For example, efforts to collect Medicare accounts must be:
  - a. similar and consistent to non-Medicare patient accounts collection procedures,
  - b. in compliance with the 120 day rule,
  - c. fully documented regarding indigence determinations,
  - d. the account must be written-off to zero balance.

VI. Medicare Bad Debts

- A. Although bad debts are not deemed to be allowable costs, the Medicare program will reimburse a provider for Medicare deductibles and co-insurance amounts which the provider has been unable to collect and which qualify as bad debts. This is an accord with the intent of Congress that the costs of services rendered to individuals covered by Medicare not be borne by those not covered; and, conversely, that the costs of services rendered to individuals not covered by Medicare not be borne by the Program. Obviously, a provider's failure to collect Medicare deductibles and co-insurance amounts would result in individuals not covered by Medicare paying partly for covered services.

**VII. Criteria for Allowable Bad Debt**

- A. A debt must meet these criteria to be an allowable bad debt:
1. the debt must be related to covered services and derived from deductible and co-insurance amounts,
  2. the provider must be able to establish that reasonable collection efforts were made,
  3. the debt was actually uncollectible when claimed as worthless,
  4. sound business judgement established that there was not likelihood of recovery at any time in the future.

**VIII. Reasonable Collection Effort**

- A. To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and co-insurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls, or personal contacts with the party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

1. Collection Agencies

A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer to all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due to the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and co-insurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

2. Documentation Required

Copies of the bill(s), follow-up letters, reports of telephone and personal contacts, etc should document the provider's collection effort in the patient's file.

**IX. Collection Fees**

- A. Where a provider utilizes the services of a collection agency and the reasonable collection effort described in S310 is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

- B. When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects \$40 from the beneficiary, and its fee is 50%, the agency keeps \$20 as its for the collection services and remits \$20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency (\$40) in the patient's account receivable and record the collection fee (\$20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as bad debt.

X. Presumption of Non- Collectibility

- A. If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

XI. Indigent or Medically Indigent Patients

- A. In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods of determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
1. the patient's indigence must be determined by the provider, not by the patient (e.g., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence),
  2. the provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, income, and expenses. In making this analysis, the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence,
  3. the provider must determine that no source other than the patient would be legally responsible for the patient's medical bill (e.g., Title XIX, local welfare agency, or guardian),
  4. Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the S310 procedures.

Note: (\*310.1-Medicare Provider Reimbursement Manual)

XII. Accounting Period for Bad Debts

- A. Uncollectible deductibles and co-insurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts, which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records ledger cards and source documents to support its claim for a bad debt for each account included. Examples of the types of information to be retained may include, but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of services for Part B bills; date of bills; date of write-off; and a breakdown of the uncollectible amount by deductible and co-insurance amounts. This proposed list is illustrative and not obligatory.

XIII. Recovery of Bad Debts

- A. Amounts included in allowable bad debts in a prior period might be covered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible.
- B. Where the program for bad debts reimbursed the provider for the reporting period in which the amount recovered was included in allowable bad debts; reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

Note: (\*310.1-Medicare Provider Reimbursement Manual)

XIX. Medicare Bad Debts Under State Welfare Programs

- A. Prior to 1968, Title XIX State Plans under the Federal Medical Assistance Programs were required to pay the Part A deductible and co-insurance amounts for inpatient hospital services furnished through December 31, 1967. Any such deductible or co-insurance amounts not paid by the State were not allowable as bad debt.
- B. Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and co-insurance amounts for services that are beyond the scope of the State Title XIX Plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid patients is not obligated (unless made part of the State Title XIX Plan) to pay all or part of the Medicare co-insurance from the 61<sup>st</sup> day on. For services that are within the scope of the Title XIX Plan, States continue to be obligated to pay the full deductible and co-insurance for categorically needy persons for most services, but can impose some cost sharing under the plan or medically needy persons as long as the amount paid is related to the individual's income of resources.
- C. Where the State is obligated either by statute or under the terms of its plan to pay all, or any of the Medicare deductible or co-insurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or co-insurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of S312 or, if applicable, S310 are met.

- D. In some instances, the State has no obligation to pay, but either does not pay anything or pays only part of the deductible or co-insurance because of State payment "ceiling". For example, assume that a State pays a maximum of \$42.50 per day for SNF services and the provider's cost is \$60 a day—the co-insurance is \$32.50 a day so that Medicare pays \$27.50 (\$60 less \$32.50)—in this case, the State limits its payment towards the co-insurance to \$15.00 (\$42.50 less \$27.50). In this situation, any portion of the deductible or co-insurance that the State does not pay that remains unpaid by the patient, can be included as bad debt under Medicare, provided that the requirements of S312 are met.
- E. If the State is not participating under Title XIX, but State or local law requires the welfare agency to pay the deductible and co-insurance amounts, any such amounts are not included in allowable bad debts. If either the Title XIX Plan or State or local law requires the welfare agency to pay the deductible and co-insurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are included in allowable bad debts provided that the requirements of S312, if applicable, or S310 are met.

XX. Applying Collections From Beneficiaries

- A. When a beneficiary or a third party, on behalf of the beneficiary, makes a partial payment of an amount due, the provider, which is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to Part A deductibles and co-insurance, Medicare Part B deductibles and co-insurance, and non-covered services. The basis for proration of partial payments is the proportionate amount of amounts owed in each of the categories.

Note: (\*310.1-Medicare Provider Reimbursement Manual)

## ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Peter Barbera, *Audit Manager*

Lloyd Myers, *Senior Auditor*

Dicky Sanford, *Auditor*

Bob Julian, *Auditor*

Technical Assistance

Fran Cowper, Regional Statistical Specialist

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.